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# BULLETIN of the MENNINGER CLINIC

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BULLETIN of the
MENNINGER CLINIC

VOLUME 12 JANUARY, 1948 NUMBER 1

# FACTS AND STATISTICS OF SIGNIFICANCE FOR PSYCHIATRY*

WILLIAM C. MENNINGER, M.D.

It used to be generally assumed that the mentally ill could be separated from the general population and segregated in hospitals under the care of physicians, who were themselves, also, segregated from civil life by reason of their occupation.

This assumption has changed so gradually and yet so radically that psychiatrists are not yet fully aware of the extent of their field. Its scope began to enlarge by leaps and bounds when psychiatrists emerged from institutions and began to treat people who had not retreated from life but were struggling bravely in midstream. These extramural patients were not isolated; they remained in contact with family, employer, friends, enemies, schools, courts, prisons, social agencies, industry, labor and a host of other external factors while they were seeking an answer to personal problems.

Unfortunately there were far too few psychiatrists to keep up with this expanding field. It is not surprising that psychiatrists, confronted with tremendous demands and seemingly endless opportunities to apply psychiatric principles to human problems, and hampered by a lack of trained co-workers, felt it advisable to limit their efforts to clinical work with a few patients rather than to try to solve the ills of the world.

This modesty in aim accounts in part for the apparent apathy of psychiatrists toward broad social problems of our time. But it does not absolve them from some responsibility, either in their own minds or in that of the public.

Psychiatrists are citizens with a certain amount of specialized knowledge which can be applied to social problems. There are an increasing number who believe that even if our knowledge of these problems and their solution is inadequate and untried, it should be extended by research and education and re-enforced by the enlistment of more personnel.

Most of us in psychiatry have little opportunity to survey the needs in

* Part of the statistical material in this paper was presented at the Annual Meeting of The Menninger Foundation, Dec. 3–4, 1946, in Topeka. These data with many additions were brought up to date for publication October, 1947. The illustrations were prepared by Mr. William H. Campbell of the Visual Aids Section of Winter Veterans Administration Hospital, Topeka.

our own field. It might be argued that when there are not enough psychiatrists, psychologists and social workers to take care of the patients who want treatment immediately, it is useless to uncover the extent of the total need. But it is only as we appraise existing facilities, opportunities and needs that we can estimate shortages, recruit personnel, and establish goals. Only as we survey the situation can we make plans for preventive measures.

The facts and figures in this presentation have been collected over a period of many months. No attempt has been made to give interpretations or discussion, inviting as such an attempt has been. Rather, an effort has been made to collect those data of special significance to psychiatry, with the references as to their sources, and to permit the figures and facts to stand by themselves for what use others might make of them. They are presented in outline form as being the most practical for covering so great an area of interest.

I. Survey of Maladjustment (mental illness).

A. Evidence and facts regarding the extent and incidence

1. *In military service*

a. *Draft results:*

15,000,000 men examined[1]

1,846,000 men rejected for NP disorders (12%)

These were 38% of all men rejected for all causes

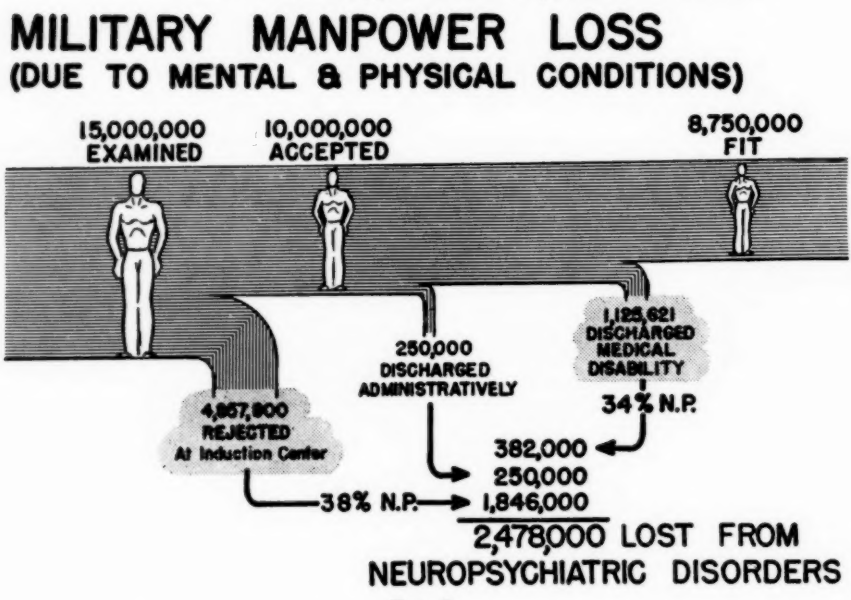


FIG. I.

[1] All army figures obtained through the Medical Statistics Division, Office of The Surgeon General, 1946.

b. *Hospital admissions:*

Army: approximately 1,000,000[1] for psychiatric disorders which were 6% of all hospital admissions. Number of *different* individuals is estimated at 750,000 to 800,000.

Navy: approximately 150,000 for psychiatric disorders[2]

c. *Medical discharges:*

Army: 387,000[1] or 37% of 1,049,000 discharges for medical disability were for NP reasons.

Navy: 76,621 or 32.4% of all medical discharges were due to NP disorders.[2]

d. *Administrative discharges:*

Army: 163,000[1] (for reasons of psychopathic personality, mental deficiency, drug addiction, homosexuality)

Navy: 91,563 men were "separated" from training centers because of NP reasons.[2]

e. *Total manpower loss from all discharges:*

718,286 men discharged for personality problems

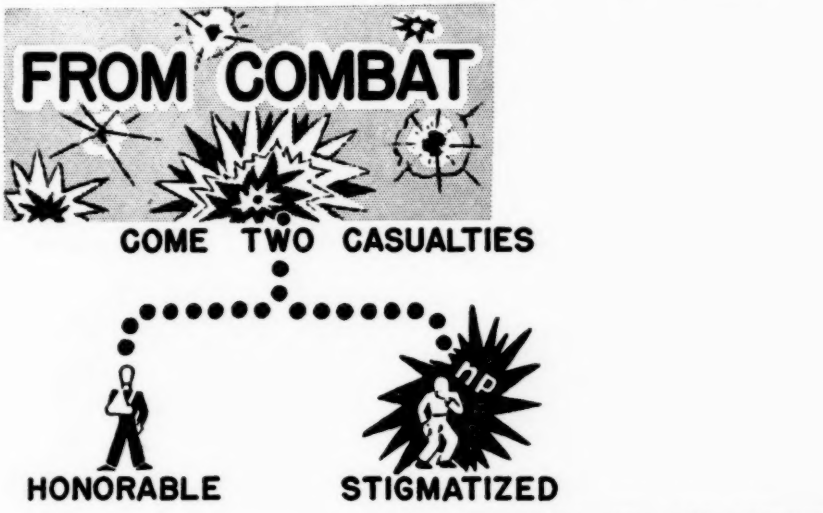
FROM COMBAT
COME TWO CASUALTIES
NP
HONORABLE
STIGMATIZED
AND YET BOTH MEN ARE VICTIMS OF CONDITIONS OVER WHICH THEY HAVE LITTLE OR NO CONTROL.

FIG. II.

2. *In mental hospitals*

a. 97% of hospitalized mental patients are in public hospitals. 87% of these are in State Hospitals.[3]

[2] Braceland, F. J.: Psychiatric Lessons from World War II. *Am. J. Psychiat.*, 103: 587–593, March 1947.

[3] *Patients in Mental Institutions*, 1942. Department of Commerce, Bureau of the Census. Washington: Government Printing Office, 1944.

b. 100,000 new admissions to State Hospitals in 1943[4]
67,000 discharges
33,000 net annual increase in hospital population
271,209 admissions to mental hospitals in 1946[5]

c. In 1945, 1,738,944 beds in *all* hospitals (general and special, private and public)
657,393 beds in mental hospitals.
That means that 38% of all hospital beds were for psychiatric use and 68% for all other types of patients in U. S. in 1945.[6] In 1946, 1,468,714 beds in all hospitals; 674,939 beds in mental hospitals, or 46% of the total beds in 1946. (Great loss in total hospital beds in 1946 due to closure of Army-Navy hospitals)[5]

d. American Hospital Association figures for year ending Sept. 1946, are somewhat different.[7]
568,473 beds in mental and allied conditions hospitals
556,474 beds in general and special hospitals of both short-term and long-term types. According to these figures 51% of all hospital beds are for mental patients. If one includes tuberculosis beds (74,867) and federal hospital beds (235,964), this gives a total of 1,435,778 beds. Of this total, psychiatric beds represent about 40%.

3. "*Minor*" *mental disorders*

a. *In military service:* 3% to 7% of all trainees consulted[8] the Mental Hygiene Clinics; only 7% of those who did so had to be hospitalized.
Unknown but large number consulted division psychiatrists and flight surgeons who did not have to be referred to hospital. These figures and facts should be considered in light of the known number of admissions for psychiatric reasons to Army hospitals.

[4] Bureau of Census Figures quoted by Dr. Frank Fremont-Smith: New Opportunities for Improvement of Mental Hospitals. Talk given to Mental Hospital Section, American Hospital Association, October 1946.

[5] Arestad, F. H., and Westmoreland, M. G.: Hospital Service in the U. S. *J. A. M. A.*, 133: 1066–1067, Apr. 12, 1947.

[6] Arestad, F. H., and Westmoreland, M. G.: Hospital Service in the U. S. Council on Medical Education and Hospitals of the American Medical Assn. *J. A. M. A.*, 130: 1073, April 20, 1946.

[7] *American Hospital Association Directory, 1947.* Information furnished by R. B. Almack, Research Analyst, American Hospital Association, June 23, 1947; M. J. Norby on Sept. 9, 1947.

[8] Guttmacher, M. S.: Army Consultation Services. *Am. J. Psychiat.*, 102: 735–748, May 1946.

b. *In civilian life:* Spot surveys indicate that 30%[9] of hospitalized general and medical and surgical cases are more or less neurotic; 58% of an unselected group of cases display harmful emotional reactions and in 26% the emotional reactions were the chief cause of the illness.[10]

48% of patients consulting gastro-enterologists have no organic gastrointestinal disease.[11]

There has been a wide variation in estimates of the incidence of "functional" disorders among all patients consulting physicians: Rennie 50%; Kirk 50%; Halliday 33%; Strecker 50% to 70%; Clarke 49% of pediatric practice; Cavanaugh 33%; Weiss 35%; Wearn 50%; Hathaway 30–60%; Harrison 60–70%.[12] 40–60% of cases in general hospitals are primarily psychiatric.[13]

B. *Facilities and personnel*

1. *Conditions*

a. State Hospitals were over-crowded by 12.3% in 1945;[14] 17.5% in 1946.[15]

11 states in 1945 with no over-crowding of patients: R. I.,

[9] Mittelmann, B. et al.: Personality and Psychosomatic Disturbances in Patients on Medical and Surgical Wards. *Psychosomat. Med.*, 7: 220–223, July 1945.

[10] Robinson, G. C.: *The Patient as a Person.* New York, Commonwealth Fund, 1939, pp. 388–414.

[11] Stevenson, Geo. S.: Why Patients Consult the Gastro-Enterologist. *J. A. M. A.*, 94: 333–337, Feb. 1, 1930.

[12] Rennie, T. A. C., quoted by Rymer, C. A.: Psychiatric Education. *Am. J. Psychiat.*, 102: 548–551, Jan. 1946. Kirk, N. T.: *Bull. U. S. Army Med. Dept.*, 78: 40, July 1944. Halliday, J. L.: Psychoneurosis as a Cause of Incapacity Among Insured Persons. *British Med. J.*, Supplement, p. 85, Mar. 9, 1935 and p. 99, Mar. 16, 1935. Strecker, E. A.: *Fundamentals of Psychiatry.* Philadelphia, J. B. Lippincott, 1942, p. 4. Strecker, E. A.: Psychiatric Education. *Mental Hygiene*, 14: 797–812, Oct. 1930. Clarke, E. K.: Old Problems in New Settings. *Journal-Lancet*, 63: 129–131, May 1943. Cavanaugh, J. R.: The Psychosomatic History. *Med. Ann. of District of Columbia*, 15: 325–329, July 1946. Weiss, Ed.: Psychosomatic Medicine and the General Physician. *Delaware St. Med. J.*, 13: 181–184, Sept. 1941. Wearn, J. T.: The Challenge of Functional Disease. *J. A. M. A.*, 134: 1517–1520, Aug. 30, 1947. Hathaway, S. R.: Multiphasic Personality Inventory. *Modern Hospital*, 66: 66–67, Apr. 1946. Harrison, F. M.: Role of the Emotions in Disease. *Delaware St. Med. J.*, 19: 79–83, May 1947.

[13] Ebaugh, F. G.: *The Care of the Psychiatric Patient in General Hospitals.* Chicago, Amer. Hosp. Assn., 1940.

[14] *Normal Capacity, Administrative Staff and Expenditure of State Hospitals for Mental Disease.* 1945. Dept Commerce, Bureau of Census, Series MP #13, April 3, '47.

[15] Current Population Reports, Mental Institutions. Bureau of Census. Series P-85, No. 17, Sept. 10, 1947.

Ind., S. Dak., Neb., N.C., Tenn., Ala., Tex., Mont., Wyo., N. Mexico.

26 States in 1945 with 1 to 20% over-crowding.

11 States in 1945 had 20% over-crowding or more: Vt., N.J., Penn., Ia., Del., W. Va., Ga., Ky., La., Ariz., Calif.; most overcrowded in 1946 were Arizona with 58.4%; Louisiana 57.4%; Illinois 50.1%.[15]

Variously estimated that 130,000 to 191,000 additional beds are needed in mental hospitals.[16]

b. *Only limited care is available in general hospitals.* There are 4,302 general hospitals in the U. S. In 1940, only 63 had any kind of facility even for mildly ill psychiatric patients. Many refuse to take care of any psychiatric patients.[13]

c. *Community clinics.* In 1944, 600 clinics but need for 1300 child guidance clinics; 25 states without any type of community psychiatric clinic.[17]

The 1944 Directory of Psychiatric Clinics lists 341 community psychiatric clinics, 175 of which accept or are exclusively for children. (New York had 126 of the total and 20 states had none!)[18]

Free psychiatric clinics in all number 688. 285 of these for children only; of the total number, 310 are community clinics and 373 are divisions of State or County government.[19]

d. *College mental hygiene.* Survey[19a] conducted for the Third National Conference on Health in Colleges solicited information from 1,000 colleges and universities; 300 answered. Regarding mental hygiene, these reported:

152 colleges stated that "medical counseling in mental hygiene" is available to students.

145 colleges stated that psychiatric consultation is available through the student health service.

90 colleges stated that courses in "mental hygiene" are

[16] Felix, R. H.: Psychiatric Plans of the USPHS. *Ment. Hyg.*, 30: 381–389, July 1946.

[17] Elliott, M. M.: *Testimony on National Neuropsychiatric Institute Act.* Mar. 8, 1946, S1160, Government Printing Office, 1946, p. 94.

[18] *Directory of Psychiatric Clinics.* New York: National Committee for Mental Hygiene, 1944.

[19] *Social Work Year Book*, 1947. New York: Russell Sage Foundation, 1947, pp. 319–320.

[19a] Personal communication from Dr. Charles E. Shepard, secretary of the Third National Conference on Health in Colleges.

offered for college credit. Of this number, 79 gave information as follows: Course is required in 13; elective in 66; average total class hours of course is 37; average annual enrollment in course is 63; usual class size averages 27.

2. *Costs*

a. *Standards* approved by American Psychiatric Association.[20]
$5.00 per day for acute and recovering patients,
$2.50 per day for chronic cases.

b. *Actual costs* (General hospital patients $7–11 per day)[21]
(Average rate for single room in 1,645 reporting general

FIG. III. Budget needs in state hospitals

hospitals in U. S. is $8.57 plus all extras—drugs, anesthesia, x-ray, medical costs, etc.)[21a]

$386.80 per year per patient in state hospitals in 1945[14] (This is up $20 per year from 1944); $445.85 in 1946.[15]

$563.11 per year in 1945 per patient in Wisconsin was highest; $644.82 in 1946.

$197.55 per year in 1945 per patient in Kentucky was lowest; $219.64 in 1946.

[20] American Psychiatric Association Committee on Public Education, released May 29, 1946.

[21] See *Hospitals*, 20: 49, Sept. 1946; also article by Clark, G. J.: Rates—Establishing Them on a Sound Basis. *Hospitals*, 21: 35–38, July 1947.

[21a] Rate Structure Variations. A National Survey. *Hospitals*, 21: 33–35, Sept. 1947.

$165,743,122 total cost for year in 1945

$1.05 per day per patient, national average in 1945; $1.22 in 1946

500–700 million dollars would be the cost if minimum standards outlined above would be met.[22]

Other figures of cost:

| | 1937[23] | 1944[24] |
|---|---|---|
| Maintenance of patients in State Hosp. | $230,866,000 | $301,000,000 |
| Earning loss of first admissions to State Hosp. in year | $552,720,000 | $658,000,000 |
| Maintenance and earning loss of mental illness of patients outside institutions | $331,591,000 | $332,000,000 |
| Total | $1,115,177,000 | $1,295,000,000 |

Davis estimates cost of psychiatric service in U. S. at $180,000,000 a year[25]

The following compilation of expenditures made in the U. S. last year provides some interesting comparisons:

*Examples of consumer expenditures*[25a]

| | Millions of Dollars |
|---|---|
| Food, tobacco, and beverages | 55,000 |
| Home rent and household operation | 30,700 |
| Clothing, accessories, and jewelry | 22,200 |
| Medical and dental care | 2,500 |
| Personal care, including beauty and barber shops | 2,250 |
| Maids and domestic service | 1,800 |
| Newspapers, books, and magazines | 1,500 |
| Musical instruments and radios | 1,000 |
| Funeral services, cemeteries, and tombstones | 850 |
| Flowers, seeds, and potted plants | 600 |
| Restaurant tips | 400 |
| Taxicab fares and tips | 400 |
| Stationery and writing supplies | 400 |
| *Care of patients in all mental hospitals* | 180 |

[22] Estimated by Wm. C. Menninger on basis of recommended standards.

[23] Pollock, H. M.: Economic Loss due to Mental Disease in New York State and U. S., 1937, *Mental Health*, Amer. Assoc. for Advancement of Science, Publication #9, pp. 156–164, Lancaster, Penn: Science Press.

[24] From a computation by Dallas Pratt, M.D., Nat'l. Mental Health Fdn., Jan. 1947.

3. *Personnel*
   a. *Approved standard for state hospitals*—varies with type of patient.[26]
      1 psychiatrist for 30–50 patients except for
      1 psychiatrist for 200 senile and arteriosclerotic patients.
      1 nurse for 10–50 patients depending upon nature of illness.
   b. *Army standard:*
      1 psychiatrist to 50 patients
   c. *Actual national ratio* in practice in 1945[14] computed on basis of 434,544 patients.

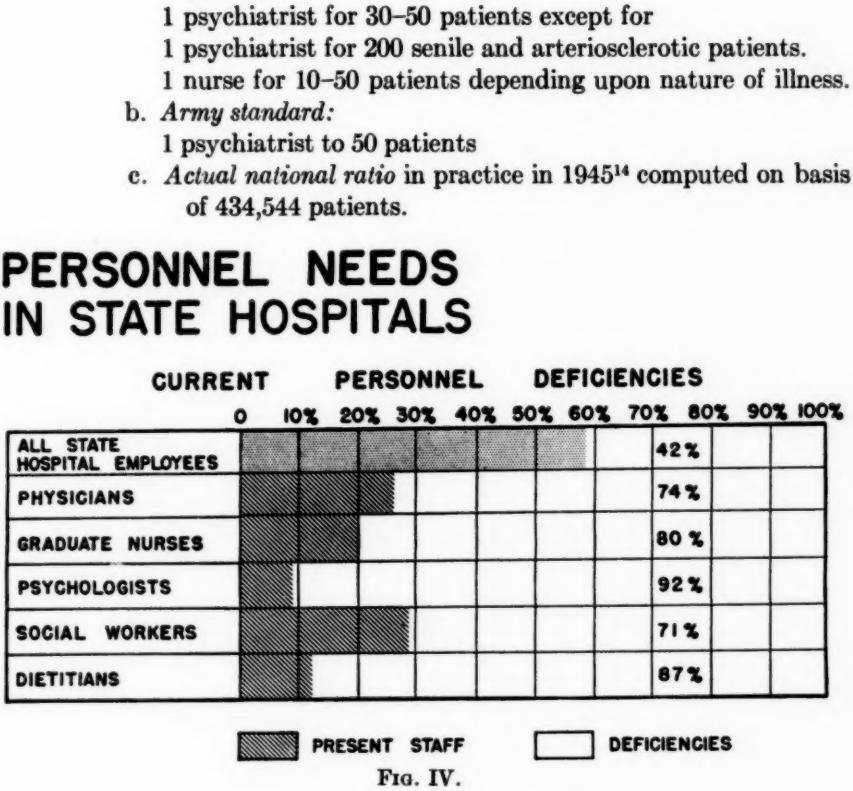


FIG. IV.

1 employee per 6.8 patients
1 physician to 298 patients
1 graduate nurse to 183 patients
Another estimate is from survey reported by Fitzsimmons:[27]
1 registered nurse to 123.9 patients.

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[25] Davis, M. M.: Costs and Organization of Psychiatric Service in U. S., Ref. 13, pp. 165–173.

[25a] *The University of Chicago Round Table*, No. 496, Sept. 21, 1947, p. 6. Published by the University of Chicago.

[26] Standards for Psychiatric Hospitals and Out-patient Clinics approved by American Psychiatric Association. 1945–46. *Am. J. Psychiat.*, 102: 264–269, Sept. 1945.

[27] Fitzsimmons, Laura: Report of a Survey of Nursing in Mental Hospitals in U. S. and Ontario, Canada. *Am. J. Psychiat.*, 100: 623–627, Mar. 1944.

d. *Deficiencies in personnel*

Estimated on basis of standards of the American Psychiatric Association as announced in 1941 as to number of personnel on duty in that year.[16]

Deficit of: 42% in number of employees of all categories
74% of physicians
92% of psychologists
80% of graduate nurses
87% of dietitians
71% of social workers

Reports from 184 State Hospitals in 1945 stated that:[14] 31 states have no clinical psychologists; 5 states have only one; 11 states reported no social workers; 10 states had only one.

II. Psychiatric Personnel

A. *Present personnel*

1. *Psychiatrists:* 4,432 psychiatrists are members of the American Psychiatric Association.[28] Many of these are administrators and retired. 40 are honorary and corresponding members. 1,110 are Fellows (senior psychiatrists) and life members. 2,966 are Members. 316 are associates (those with one year of training or experience. Approximately 2,475 of these men are diplomates of the American Board of Neurology and Psychiatry, in psychiatry, which qualifies them as "specialists"[29]; in 1946, in 40 reporting states, there were 1,319 physicians in state mental hospitals.[15]

2. *Clinical Psychologists:* a title not yet strictly uniform in its significance. Certifying board is just being established. The secretary of the Clinical Psychology section of the American Psychological Association reports approximately 1500 members.[30]

3. *Psychiatric Social Workers:* This group has inadequate standards and an uneven criteria but a rough estimate indicates that there are about 3000 psychiatric social workers at the present time.[31]

[28] Communication from the Administrative Assistant, Austin Davies, dated Aug. 27, 1947.

[29] Communication from Dr. F. J. Braceland, Secretary, dated Aug. 29, 1947.

[30] Communication from Dr. David Rapaport, dated Feb. 15, 1947.

[31] Communication from Mrs. Elizabeth Ross, dated Feb. 15, 1947.

4. *Psychiatric Nurses:* Total number is unknown. There were 2,583 in State Hospitals in 1945.[14] There is no national organization of this group.

B. *Shortages*

1. *Psychiatrists:* Immediate need estimated to be 10,000[32] to 14,000.[33]

Dr. Paul Hawley indicated the V. A. could use all "first class" psychiatrists in the country.[34]

Dr. Daniel Blain indicated that V. A. had 592 psychiatrists on duty but needed 1,875; by 1960 would need 3,607.[35]

2. *Clinical psychologists:* 1,700 more were needed than available, was reported in the Senate Hearing on the Mental Health Bill.[36]

Dr. Blain reported 155 currently on duty with V. A.[35] Needs 546; 1,442 will be needed by 1960.

Dr. James Miller, Chief Psychologist of V. A., indicated that 1,500 clinical psychologists were needed immediately.[37]

3. *Psychiatric social workers:* No accurate estimates. Rough estimates of needs vary from 4,500[31] to 10,000.[36] Schools are currently graduating only 200 annually.[31] Dr. Blain reported that 341 were on duty with V. A. and the current need is for 605; by 1960 V. A. will need 2,666.[35]

4. *Psychiatric nurses:* Current need is estimated to be between 15,000[36] to 47,000.[38] Dr. Blain reports that currently there are 2,200 on duty with V. A., the need is for 4,285; by 1960 it will be 7,500.[35]

C. *Training opportunities and needs*

1. *Psychiatrists*

a. *Medical school curriculum:* Of approximately 5,000 hours in the four-year medical school curriculum, only 1% to 5%

[32] Rennie, T. A. C.: Needed: 10,000 Psychiatrists. *Ment. Hyg.*, 29: 644-690, Oct. 1945.

[33] Felix, R. H.: Mental Public Health: A Plan of National Scope. Annual Meeting Mass. Soc., *Ment. Hyg.*, Jan 24, 1946—N. M. H. F. reprint #20.

[34] Hawley, P. R.: Neuropsychiatric Problems of the Veterans Administration. *Milit. Surg.*, 99: 759–762, Dec. 1946.

[35] Communication from Dr. Blain, Director of Neuropsychiatry for V. A., dated Mar. 5, 1947.

[36] Pepper, C.: National Mental Health Act. Senate Report #1353, May 16, 1946.

[37] Communication from Dr. Miller dated March 10, 1947.

[38] National League of Nursing Education Pamphlet, *New Frontiers in Psychiatric Nursing*, 1945.

of the hours are allotted for training in psychiatry. The higher figure might be sufficient provided that psychiatric orientation permeated the teaching in other subjects.[39]

b. *Graduate education opportunities:* 97 residencies (three-year post graduate training in university hospital) in 1945.[40] 410 "approved" internships and residencies in psychiatry were listed in 111 hospitals in 1940 by the American Medical Association. In 1946 the same authority listed 758

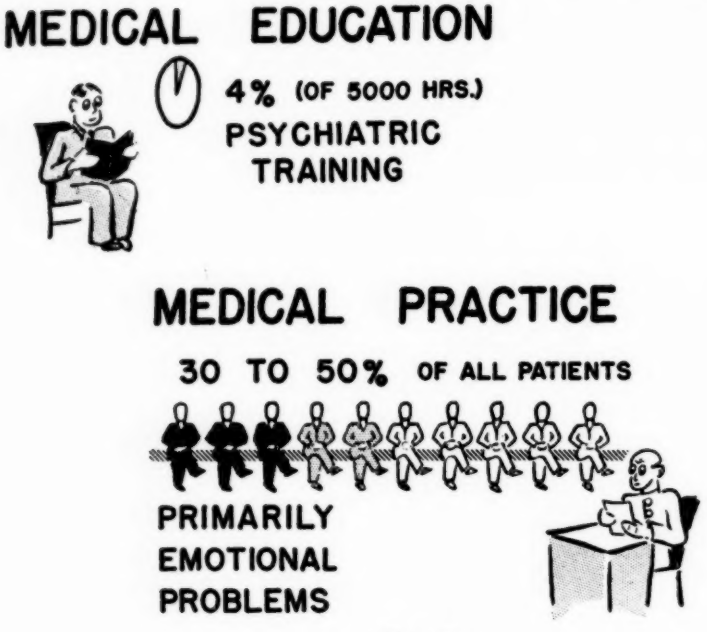


FIG. V

in 155 hospitals.[41] In 1947, there were 1,297 in 193 hospitals, but in 79 hospitals these were for only 1 year period.[42]

V. A. currently has 401 residencies in psychiatry and this is expected to increase to 600 in 1948 and to 1083 by 1960.[35]

[39] Ebaugh, F. G., & Rymer, C. A.: *Psychiatry in Medical Education*, New York: Commonwealth Fund, 1940, pp. 14–18.

[40] Figured out unofficially in A. M. A. office, 1946.

[41] Approved Residencies and Fellowships. *J. A. M. A.*, 115: 777, Aug. 31, 1940. Approved Residencies and Fellowships. *J. A. M. A.*, 131: 1342, Aug. 17, 1946.

[42] Approved Residencies and Fellowships. *J. A. M. A.*, 134: 1319, Aug. 16, 1947.

2. *Clinical psychologists:* 31 universities offer training in this field but there is a shortage in facilities for "clinical" training.[37]
   V. A. now has 200 student clinical psychologists in training. This number is expected to increase to 1,200 in 1950.[35]
3. *Psychiatric social workers:* 14 schools are now approved for the training of social workers in the field of psychiatry.[31]
   V. A. is providing the "field training" for 120 and this number is expected to increase to 524 in 1950.[35]
4. *Psychiatric nurses:* Psychiatric nursing is now included as a post-graduate course in the curricula of 10 universities and several graduate training centers.[38]

III. Research
   A. *Money invested*
      1. *Industrial research:* from 116 million in 1930 the amount of money invested increased to 240 million dollars in 1940.[43]
      2. *Scientific research* under government control rose from 50 million in 1938 to 720 million in 1944.[43]

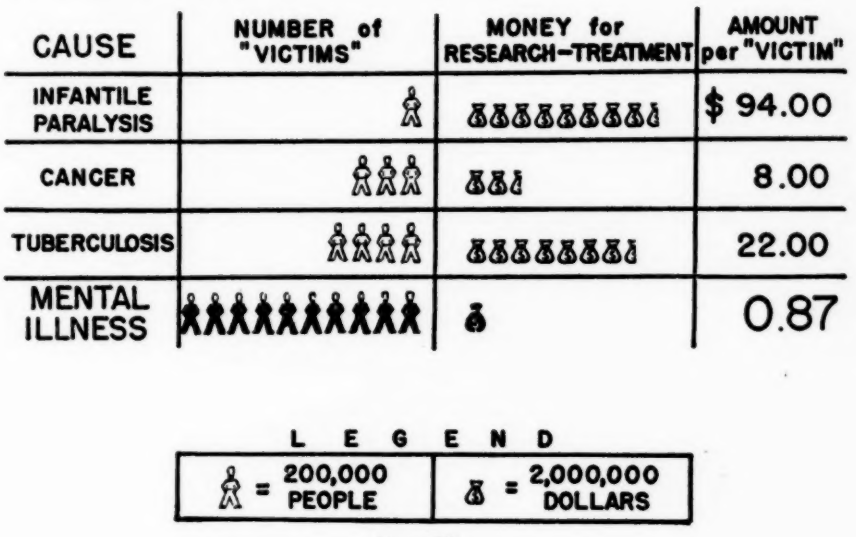


FIG. VI.

[43] Bush, V.: *Science, the Endless Frontier.* Washington: U. S. Government Printing Office, 1945. page 80.

3. *Medical research* in 1944 was estimated to cost only $54,650,000.[44]

4. *Psychiatric research*, estimated to amount only to about $2,000,000 a year although the loss from mental ill health amounts to over $1,000,000,000.[36] For every dollar spent on psychiatric research in this country, we spent $65 in other medical research and $2,500 in industrial research.[45] In poliomyelitis we spent $100 per case and in psychiatry, $.25 per year for each estimated case of mental illness and only $1.00 for each known case of total disability for mental ill health.[36]

B. *Extent:* Of 613 non-governmental medical institutions, only 37 professed to be doing any research in psychiatry in 1942. 17 of those presented small, informal projects with no evidence of an established research program.[46]

IV. Status of Psychiatry in Special Programs

A. *Academic education*

1. *Mental hygiene consultation services:* There is no organization of psychiatrists serving in college mental hygiene. However, there is a Mental Hygiene Committee of the American Student Health Association.

It is estimated that there are 10–15 universities and colleges[47] that have a full-time psychiatrist as a mental health counsellor in the student health service. At least an equal number of universities are currently seeking a psychiatrist for this function.

2. *Principles applied to teaching:* An increasing utilization of mental hygiene principles in textbooks for teachers—see books by Prescott, Rivlin, Ryan, Sherman, Symonds, Witty, and Skinner.

B. *Criminology:* 10 adult criminal courts utilize psychiatrists part or full-time.[48] An undetermined but considerably larger number of juvenile courts have psychiatric service and consultation which varies from routine examinations to calling in consultants for special offenders, but rarely more than diagnosis.

[44] Estimated by Dr. Lewis H. Weed of the National Research Council as minimum.

[45] Kubie, L. S.: National Neuropsychiatric Act. Hearings S1160, Mar. 6-8, 1946, p. 79.

[46] National Committee for Mental Hygiene. Research in Mental Hospitals. Study #2, 1942.

[47] Communication from Dr. Clements, C. Fry, Psychiatrist, Yale Univ., dated Aug. 1947.

[48] Communication from Dr. Manfred Guttmacher.

C. *Industry:* Number of psychiatrists engaged, as of July 31, 1947.[49]

3 full-time psychiatrists in industries.

3 additional psychiatrists are associated with large business or government.

5 or 6 physicians (not psychiatrists) are doing mental hygiene work in industries.

The number of part-time psychiatric counsellors in industry is unknown.

D. *Penology*

| | Federal Institutions | State Insts. | Total[50] |
|---|---|---|---|
| Full-time psychiatrists..... | 16 | 24 | 40 |
| Part-time psychiatrists..... | 22 | 21 | 43 |

E. *Public Health*

1. Number of psychiatrists engaged:
   a. U. S. Public Health Service has approximately 60 psychiatrists.[51] The majority are in two mental hospitals maintained by the service. This number also includes all the psychiatrists in federal prison service.
   b. *State programs*[52]
      (1) Psychiatrist is a member of state public health depts. in Conn., Fla., Kans., Me., Miss., Wash., Wis. Conn. has the most developed program.
      (2) Mental hygiene program is conducted under special unit or department in the states of: Calif., Iowa, Md., Mass., Mich., N. J., N. Y., and Va.
      (5) Psychiatry is included under a department of public welfare in: Ill., Ohio, Penna., R. I., Vt., Wisc.
2. *Training:* Only school of public health which includes a full time psychiatrist[53] on the staff is Johns Hopkins.
3. *Preventive psychiatry:* Public Law 487 of the 79th Congress known as the Mental Health Act will provide funds to aid states in the development of a public health program of preventive psychiatry with matched funds. Many states, as of May 1947, had never even designated an authority with which

[49] Communication from Dr. F. W. Dershimer, Director of Psychiatry, E. I. DuPont de Nemours Co., dated July 31, 1947.

[50] U. S. Bureau of Census: Prisoners in State and Federal Prisons and Reformatories, page 98, 1945.

[51] Communication from Dr. Robert Felix, Chief of Mental Health, U. S. P. H. S.

[52] Information gained from correspondence directed to the various states.

[53] Communication from Dr. Paul Lemkau, psychiatrist at Johns Hopkins School of Public Health.

the Public Health Service could communicate as that state's representative in the field of mental health.

V. Social Problems: The following are all social problems that have an important significance for psychiatry. In some instances they represent the result of mental ill health. Some are the causes of mental ill health and still others are evidence of existing mental health.

A. *War*

1. Cost of World War II:[54]
   $335 billion to the United States, $157 million a day for duration.
   232,469 men killed in action—total deaths 392,757 (just in U. S. forces)
2. Cost of World War I:[54] $26 billion—40,000 killed in action—130,000 total deaths.

B. *Some comparative costs:* Sums of money used for certain constructive activities and luxury items show some interesting comparisons, particularly with the cost of war and crime (see A, E).

1. *Constructive expenses*

| | |
|---|---|
| Medical care, 1945 | $3,600,000,000[55] |
| Recreation, 1945 | 3,000,000,000[55] |
| Public School Expenditures, 1940 | 2,308,000,000[56] |
| Reading (books, magazines, newspapers, 1942 | 1,000,000,000[57] |

2. *Luxury expenses*

| | |
|---|---|
| Beer, wine, liquor, 1946 | 7,700,000,000[58] |
| Tobacco, 1945 | 3,100,000,000[55] |
| Jewelry, 1945 | 1,071,000,000[58] |
| Cosmetics, 1946 | 699,600,000[59] |

C. *Accidents*

350,000 disabled each year from accidents alone.[60]

Accidents, excluding motor vehicle, ranked sixth as leading cause of death in U. S. in 1944. Motor vehicle accidents ranked 10th.[61]

[54] Kieran, John: *Information Please Almanac*, 1947. Garden City, Doubleday & Co., pp. 354, 355.

[55] U. S. Dept. Commerce. Bureau of Foreign and Domestic Commerce, *Handbook of Basic Economic Statistics*, 1947.

[56] *World Almanac, 1946*. New York: New York World Telegram, p. 580.

[57] Civilian Spending and Saving 1941–1942. *Statistical Abstract of the United States*. Washington, D. C.: U. S. Government Printing Office, 1946, p. 275.

[58] Walter Lippman, *Washington Post*, April 27, 1947.

[59] Cosmetic Slump. *Business Week*, May 10, 1947, pp. 65–67.

[60] Rusk, H. A.: The Forgotten Casualty: The Disabled Civilian. *New York Times*, May 12, 1946.

[61] See ref. 54, p. 184.

In special studies it has been found that:

a) 10% of a group were responsible for 75% of accidents of that group.[62]

b) 15–33% of truck drivers surveyed accounted for 100% of accidents.[63]

c) 22% of accidents result wholly from personality causes, 60% from a combination of mechanical and personality causes.[64]

99,000 accidents in 1945 were 4th important cause of death. (Rate of 73 per 100,000 deaths; 321 for heart disease; 134 for cancer.) 10,400,000 additional suffered disabling injury—370,000 permanently. Total cost estimated by Nat'l Safety Council, 1947—$6,500,000,000. This includes medical expenses and insurance, lost wages, value of lost services, property damage, etc.[65]

D. *Alcoholism*

*Incidence:* In U. S.—600,000 chronic alcoholics, 2,400,000 excessive drinkers.[66] Estimate of 3,000,000 compulsive drinkers, ¼ of these termed "chronic alcoholics," the remainder are termed "chronic excessive drinkers." A further estimate is that 2,423,000 male alcoholics are between 20–65, representing 6.25% of the male population of these ages.[67]

Estimated number of chronic alcoholics in 1945 was 750,000 defined as "those who as a consequence of prolonged excessive drinking have developed a diagnosable bodily or mental disorder." The same expert estimates the number of inebriates (including chronic alcoholics) as 3,750,000.[68]

*Cost:* Total estimate of expenditures referable to inebriety in 1940, $778,903,000 which the writer calls a "crude estimate."[69]

[62] Bristol, L. D.: Medical Aspects of Accident Control. *J. A. M. A.*, 107: 653–655, Aug. 29, 1936.

[63] Rawson, A. J.: Accident Proneness. *Psychosomat. Med.*, 6: 88–94, Jan. 1944.

[64] National Safety Council: *Proximate Causes of 1000 Accidents.* Pamphlet ESMWT-17: 25-10-200.

[65] Rusk, H. A.: Convalescence and Rehabilitation. *Proceedings American Philosophical Soc.*, 90: 271–274, Sept. 1946.

[66] Haggard, H. W. and Jellinek, E. M.: *Alcohol Explored.* New York, Doubleday, Doran, 1942.

[67] Bacon, S. D.: Alcoholism: Its Extent, Therapy and Prevention. *Federal Probation*, 2: 24–32, April–June 1947.

[68] Jellinek, E. M.: Recent Trends in Alcoholism and Alcohol Consumption. *Quart. J. Studies on Alcohol*, 8: 1–42, June, 1947.

[69] Landis, B. Y.: Certain Expenditures on Account of Inebriety. *Quart. J. Studies on Alcohol*, 6: 59–91, June 1945.

A second estimate: "for those who are unsatisfied unless costs can be defined in terms of dollars and cents, it has been estimated on the basis of 1940 data that alcoholism cost the American public about 1 billion dollars for that year; this estimate probably was conservative."[67]

25% of the arrests in 1942 (145,946 of 585,988) were for drunkenness.[70]

E. *Crime*

1. *Extent:* In 1946—18,698 prisoners in federal institutions, and approximately 118,000 prisoners in state penal institutions; 25–30,000 "prisoners" under 21 years of age; in addition to above, there are an average of 110,000 in jails and workhouses.[71]

Arrests in 1942 for violations of state laws and municipal ordinances—585,988.[70]

Crimes in 1946 broke all recordsf or the last decade with a total of 1,685,203 during the year, an increase of 119,633 over 1945.[72]

2. *Cost:* Variously estimated to be between 10–18 billions of dollars a year.[73] Adult criminal justice is estimated to cost $250,000,000 a year[73] and it is estimated that it costs us $100,000,000 a year to operate the 147 federal and state penal institutions.[71]

F. *Delinquency*

1. *Extent:* 122,851 offenders passed through 374 juvenile courts in 1945[74]

29,109 "pupils" were in 142 schools for juvenile delinquents[75]

250,000, and possibly as many as 400,000 under 18 years through juvenile courts each year.[17]

G. *Education*

In 1940: 3.7% (2.8 million) persons 25 years or older in U. S. had no schooling.

[70] *Statistical Abstracts of the United States.* Washington, Government Printing Office, 1943, p. 95.

[71] Communication from J. V. Bennett, Director of Bureau of Federal Prisons, dated March 20, 1947.

[72] News release, Department of Justice, Federal Bureau of Investigation. Mar. 5, 1947.

[73] Morris, A.: *Criminology.* New York: Longmans, Green & Co., 1938, page 20.

[74] *Juvenile Court Statistics 1944–1945.* Social Statistics, Federal Security Agency. U. S. Children's Bureau.

[75] See ref. 70, p. 226.

13.5% (10.1 million) had completed fewer than 5 years of schooling.[76]

In Army: 8% had an AGTC score under 70, a total of 685,362 men. Literacy training was provided for 107,075.[77]

Comparative figures of countries with lower illiteracy rates than U. S.:

Denmark—0.1; England and Wales, 0.34; Irish Free State, 2.0; Japan, 0.88; Netherlands, 0.31; Scotland, 0.29; Sweden, 0.21; Switzerland, 0.39.[78]

Only ¼ of those who leave school do so because they are not interested. Over ½ drop out because they cannot afford to stay.[79]

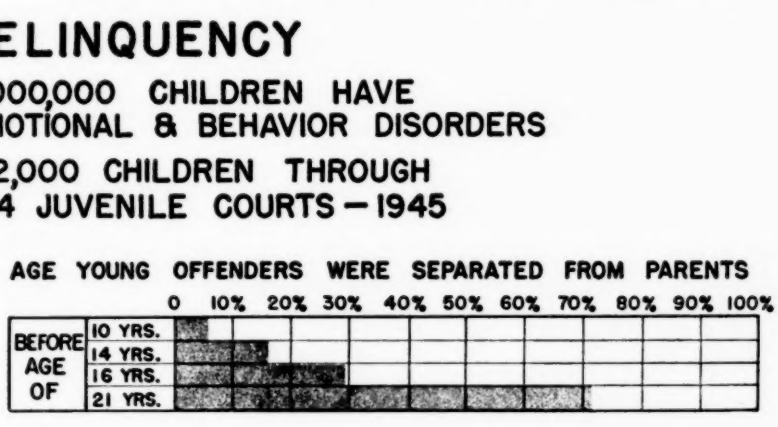
DELINQUENCY
3,000,000 CHILDREN HAVE EMOTIONAL & BEHAVIOR DISORDERS
122,000 CHILDREN THROUGH 374 JUVENILE COURTS — 1945
AGE YOUNG OFFENDERS WERE SEPARATED FROM PARENTS
0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
BEFORE AGE OF
10 YRS.
14 YRS.
16 YRS.
21 YRS.
80% OF THOSE IMPRISONED ARE UNDER 25 YEARS OF AGE

FIG. VII.

2,000,000 children between ages of 6 and 15 were not in any kind of school in 1940.[80]

H. *The family organization*

1. *Divorce:* 1915—10.3 marriages per 1000; 1.0 divorces[81]

[76] Bureau of Census. Series P-10, #8, Apr. 23, 1942.

[77] Witty, P. A. and Goldberg, S.: The Army's Training Program for Illiterate, non-English Speaking and Educationally Retarded Men. *Elem. Eng. Rev.*, 20: 306–311, Dec. 1943.

[78] Lindegren, A. M.: Literacy and Illiteracy in Various Countries of the World. *Education for Victory.* (U. S. Office of Education) 3: 8–9, May 21, 1945.

[79] *Talk It Over.* National Institute of Social Relations Y101, 1946, page 8.

[80] Norton, J. K. and Lawler, E. S.: *Unfinished Business in American Education.* Washington, American Council on Education, 1946.

[81] Vital Statistics. Special report V 23, #9, Sept. 10, 1946: *Marriage and Divorce in the United States, 1937–1945* by B. L. Jenkinson.

1935—10.4 marriages per 1000; 1.7 divorces
1945—12.3 marriages per 1000; 3.6 divorces
Actual: 249,000 divorces in 1937; 502,000 divorces in 1945.

2. *Children:* 47.8% of families have no children under 19 years of age,[82] 21.7% have only one. 35,087,440 families in U. S. in 1940[83] of which 17,164,680 had no children under 18 years of age; 7,467,960 had only one child under 18 years of age; 5,372,280 had 3 or more children.
3. *Illegitimacy:* 83,000 births out of wedlock in 1943 in U. S. exclusive of 10[84] large states which do not record legitimacy on registrations. Almost ½ of these births were to mothers 15–19 years of age.
4. *Women employed:* 16 million women at work away from home in March 1944,[87] 7 million of whom were single; 7 million were married; 2 million were divorced or widowed. In June 1947 there were 18,150,000 women employed or 28.8% of the female population over 14 years.[85]

   6,140,000 entered business or industry for the first time during war years.[86]

   2,770,000 employed women in 1944 had 4,460,000 children under 14 years of age. 750,000 of these children were in fatherless homes.[84] In Feb. 1946, nearly a million women working were mothers of children under 6 years of age; 22.5% of mothers with children under 18 but over 5 working outside the home.[85]
5. *Time* magazine reported that the number of *private households* in U. S. increased 12% in last seven years to a total of 39,138,000. Doubling up has increased to 2,764,000 married couples living with other families.[87]
6. *College graduates*, both men and women, fail to reproduce sufficient off-spring to replace themselves; it is calculated that

[82] *A Program for National Security.* Report of President's Advisory Commission on Universal Training. Washington, D. C., U. S. Government Printing Office, May 29, 1947, p. 170.

[83] See ref. 70, p. 52.

[84] *Building the Future for Children and Youth.* U. S. Dept. Labor Children's Bureau, Pub. 310. Washington. Page 21.

[85] Women as Wage-earners. *New York Times*, Sept. 14, 1947, quoting from U. S. Dept. of Labor.

[86] *Women in the Post-War.* Women's Advisory Committee, War Manpower Commission, Washington, April 1945.

[87] *Time Magazine*, Sept. 29, 1947, p. 28.

2.22 children must be born per graduate to allow a child to reach the same age at which the parent graduated. Classes of men from 1922 had 1.7 children per graduate, classes of 1937 had 1.11 children per graduate. Women graduates of 1922 reported 1.36 children per graduate; classes of 1937 reported 1.06 children per graduate.[87a]

I. *Housing:* National Census in 1940 revealed that only 61.7% of 27,723,008 non-farm[88] homes were "standard." (Standard home is one needing no major repairs and possessing modern plumbing—private flush toilet and bath.) 3,500,000 plus, did not have private toilet and bath; 3,000,000 more lacked running water and plumbing of any description.

Need approximately 3,200,000 new living units.[88]

In October, 1945, 1,200,000 families were living doubled up with others.

2,900,000 married veterans needed homes; 560,000 non-veterans were establishing new families. In 1946 we were able to build only 400–500,000 homes a year.

The national goal—1,000,000 residential units in 1947.[89] 1,500,000 in subsequent years. "Present indications are that not more than 750,000 units will be built this year, moreover this housing has been available only at high prices and has thus failed to relieve the needs of many families most in need of accommodation."

J. *Mental deficiency:* Estimated extent of mental deficiency in U. S. varies from 1,500,000[90] to 4,500,000. The second figure is estimated on the basis of the draft experience during the war when 4.5% of all men examined, a total of 676,300 were mentally deficient.[91]

In 1941 there were approximately 115,000 mental defectives in institutions[92] in the United States. 12,315 were first admissions during the year.

[87a] Figures from Population Reference Bureau, Washington, July 1947. See also *Vassar Alumni Mag.*, 24: 17–18, Apr. 1939; *Smith Alumni Quart.*, Nov. 1946; Gamble, C. J.: The Deficit in the Birth Rate of College Graduates. *Human Fertility*, 11: 41–47, June 1946.

[88] *Talk It Over*. National Institute of Social Relations, Washington, G-103, 1946, p. 2.

[89] Mid-year Economic Report of the President, transmitted to Congress, July 21, 1947.

[90] National Committee for Mental Hygiene: Personal communication, 1946.

[91] Rowntree, L. G. et al.: Mental and Personality Disorders in Selective Service Registrants. *J. A. M. A.*, 128: 1084–1087, Aug. 11, 1945.

[92] See ref. 70, p. 89.

Some 2% of children of school age have enough difficulty to prevent education in usual school. Only 1 in 10 would require custodial care if adequate facilities for supervision were available in community.[93]

K. *Minority problems*

1. *Non-white population:*

| | |
|---|---|
| Negro | 12,865,518[94] |
| Indian | 333,969 |
| Japanese | 126,947 |
| Chinese | 77,504 |
| Other | 50,647 |
| Total | 13,454,585 |

2. *Foreign born white* ..... 11,419,138[95]
(including Mexican—377,433)

3. *Religious Groups*
Catholic population (1944) ..... 23,419,701[96]
Jewish population (1937) (3.69% of total population)[97] ..... 4,770,647

4. *Some symptoms of disorder:*
Among the majority: prejudice, ignorance, tension, hate, fear.
Among the minority: unhappiness, resentment, fear, poverty, suffering.

5. *Some expressions of the problem:*
Segregation: Jim Crowism, housing, travel, recreation.
Discrimination: employment, politics, education, medical care.

6. *Survey of U. S. racial and religious intolerance* by secret ballot.[98]
36% of the American people take the view that Jews have more economic power than is good for the country.
20% feel that Jews have too much political power.
Large groups show envy, distrust or plain dislike for Negroes, Catholics and Protestants.
In no case do the apparently unprejudiced make up a majority.
Resentment of Jewish and Catholic economic power tends to run highest where such power is least evident, away from the Northeast, and also in communities of 2,500 or less and on farms. With Negroes, the opposite is true; they are disliked

[93] See ref. 84, p. 22.
[94] See ref. 70, p. 15.
[95] Ibid., p. 35.
[96] See ref. 56, p. 304.
[97] Ibid., p. 488.
[98] *Fortune* survey conducted by Elmo Roper and reported in that magazine. 36: 5, Oct. 1947.

most where they actually provide some economic competition —in the South and in farming areas.

Jews evoke the most hostility in areas where there are very few of them. They are the least-liked minority. 73% of those who had any hostility to express along economic lines and 52% of those who had hostility to express along political lines picked on Jews.

In certain areas, over one-sixth of the people feel Catholics have too much power. In the Southwest 10% of the people single out Protestants as having too much power (in the rest of the country it is 3%)

18% of country's population is Catholic

10% Negro

3–4% Jewish

70% plus Protestant.

In question with regard as to what should be done about it—an oral answer was given to this: 28% favor strong measures being taken. That means that approximately 22 million adults, would be receptive to changes in direction of greater tolerance.

L. *Physical Handicaps*

2,000,000 Americans of working age have physical impairments which prevent them from working.[60]

6,500,000 males of ages 15–64 were disabled according to report made 1940.[65]

200,000 cerebral palsy victims.[98a]

120,000 civilian amputees during first 4 years of World War II.[65]

17,000 amputees in Army during same period in World War II.[65]

4,000,000 persons suffered from permanent disability in 1940.[99]

800,000 annual increment of disabled persons of this type.

20,000,000 disabled men and women constitute $\frac{1}{7}$ of our population.[100]

1,500,000 handicapped persons in this country could be made employable.[101]

[98a] Rusk, H. A.: Muscular Retraining Help to Cerebral Palsy Victims. *New York Times*, December 29, 1946.

[99] *Safety Training Digest. Industrial Rehabilitation.* American Museum of Safety and Center for Safety Education, New York University, 1945. Excerpt from report of Baruch Committee on Physical Medicine, page 42.

[100] Rusk, H. A.: Rehabilitation. *New York Times*, Oct. 6, 1946.

[101] See ref. 99, Brig. Gen. Hines is quoted on p. 46.

Money spent for rehabilitation of disabled persons who were injured in industry or otherwise.

| | | |
|---|---|---|
| In 1942: | Federal funds | $2,556,969 |
| | State funds | 2,648,174 |
| | Cases on active roll June 30, 1942 | 31,659[102] |

It has been estimated that for every dollar spent for rehabilitation, $47 is returned to society.[99]

M. *Industrial Problems*

1. 1946—Jan. to July which was post-war peak of labor-management controversies found 3,000,000 workers directly involved in work stoppages amounting to nearly 89,000,000 man-days.[103]

   1947—Jan. to July there were 2,200 stoppages involving about 1,560,000 workers and accounted for a time loss of between 20 and 21 million man-days.[103]

   By contrast: 1928 there were 620 strikes involving 322,866 workers with a total of 13,065,634 man-days idle.[104]

2. May *Fortune Magazine* survey showed that:[105]

   Half of the nation's factory workers seem frustrated because their work gives no opportunity for personal initiative.

   41% think that even a job well done is a blind alley; they are hopeless of advancement and resigned to staying where they are.

   Over half would choose a different occupation if they had to do it over again.

   Only 21% under forty years of age (17% of those over forty) think they will ever get beyond a foreman's position.

N. *Unemployment*

1940—There were 52,789,499 of 52.2% of population composing the "labor force" in the U. S. 4.8% of this number (2,529,606) were on public emergency work; 9.6% of this number (5,093,810) were seeking work.[106]

Unemployment compensation amounted to $520,109,000 in 1940.[107]

[102] See ref. 70, p. 232.

[103] U. S. Dept. Labor, Bureau of Labor Statistics, news release, July 15, 1947.

[104] See ref. 70, p. 157.

[105] Elmo Roper: The Fortune Survey: The American Factory Worker. *Fortune Magazine*, 35: 5-6, 10-12, May 1947.

[106] See ref. 70, p. 114.

[107] Ibid., p. 182.

Forced unemployment results in mental ill health for the entire family and affects two generations simultaneously.[108]

Direct and not measurable relationship between unemployment and delinquency and crime. Government figures show that 54% of the children committeed to state "reform" institutions come from families whose incomes are rated as "poor."[109]

5,000,000 migrant workers—unorganized, unprotected by workmen's compensation laws in most states, ineligible for educational, health or welfare benefits while following the elusive dollar in seasonal shifts.[110]

G. *Venereal Disease Rates*

There are no figures to show the extent of prostitution in the United States. There probably could never be any index to the extent of non-marital sexual relationships.

One source indicated that of women married between 1932 and 1937, 68% were non-virgins.[111]

Another suggestion as to the extent of non-marital sexual relations are the venereal disease infections. (This does not include re-infections.)

1941—syphilis 466,538; gonorrhea 191,894[112]
1946—syphilis 361,830; gonorrhea 367,322

[108] Unemployment and Mental Health. Senate Hearings S380, pp. 433–445, Aug. 24, 1945; Ginzberg, Eli and associates: *The Unemployed*, New York and London, Harper & Bros., '43.

[109] *Talk It Over*. National Institute of Social Relations, Washington G-105, 1946, p. 3.

[110] Migrant Labor a Human Problem. *Report and Recommendations, Federal Interagency Committee on Migrant Labor*, March 1947.

[111] Terman, L. M.: *Psychological Factors in Marital Happiness*. New York, McGraw-Hill, 1938.

[112] Communication from United States Public Health Service, Dec. 27, 1946.

# LESSONS TO LEARN*

ALAN GREGG, M.D.

Let us consider the lessons that the war experience offers to psychiatrists, or the effects—if you prefer to make a boldly optimistic suggestion—the effects of the war upon psychiatry. For myself, I would prefer to say "the lessons that war offers psychiatrists." This caution comes from my respect for the salutary cynicism of the remark that "the only thing we learn from history is that we don't learn from history," and the cruel reality that there are none so blind as they that won't see. I remember how thoroughly Thomas W. Salmon's famous Volume Ten was neglected by those for whom it was written. The gravest issue is not what are the lessons for psychiatrists, for the military, and for society at large to be learned from the war, but whether in the urgent preoccupations of what Elton Mayo calls our adaptive society we are going to manage to learn or retain much of anything from the experience of the war. Make no mistake about it, the pressing and immediate tends to crowd out the ultimately valuable. Learned Hand said of this generation, "In its pathetic pursuit of that ever retreating pot of gold, it puts its trust in loyalties, in creeds, in causes, in regulation, in institutions, in courts, in causes, in propaganda. The one thing to which it will not trust is the vagrant mind and the self-directed soul. So be it, by their fruit ye shall know them; and do we need to be assured that our fruit is bitter." It will take some heroic effort to learn all the lessons the experience of the war offers us. It will require vagrant minds and self-directed souls.

Like any experience that is both complex and intense, the war discovered truth not known before, corrected some opinions, confirmed or proved some views not widely held before, and suggested many ideas that deserve further attention. But so neat a scheme becomes formidably complex if you realize that at least five main groups of persons made these discoveries, corrections, confirmations, and suggestions. These groups were psychiatrists, physicians who are not psychiatrists, the military, the civilian population, and the patients. Each group made its own discoveries, jubilant or poignant, changed its views reluctantly or ingenuously, proved its convictions with varying degrees of forebearance or vindictiveness, and exercised its imagination in forming questions to be studied later or casually abandoned. There is not time to make or to defend a table of results that would place each of these changes in its proper niche. But we may follow the main headings.

* Delivered at the American Psychiatric Association meeting in New York City on May 22, 1947. Reprinted by permission from the *American Journal of Psychiatry*, 104: 217, October, 1947.

## New Discoveries

Discoveries which were completely new to everyone involved were not numerous. The delineation of combat fatigue and the value of promptness in dealing with it probably deserve the term "discovery." "Sixty per cent of combat casualties were salvaged for further duty within fifteen miles of the front; an additional thirty per cent were salvaged for non-combatant jobs in overseas areas."* It was hardly news to the military that the criterion for the psychiatrist in war, centers around the objective of maintaining as large a number of effective fighting men as possible whether by preventive measures or therapeutic efficiency. But a good many doctors discovered that such a criterion implied a broader responsibility for human beings than they had ever been called upon to exercise in civilian practice. Several psychiatrists discovered the fundamental workaday value of expressing themselves in non-technical terms, whether to patients or commanding officers. May their tribe increase! They even discovered the present inadequacy of their own professional nomenclature and its futility unless subject to revision. Psychological tests, when sufficient time was permitted for them to be made thoroughly, proved to have predictive value and this was at long last revealed to the military mind, though no one would infer that the military authorities had any large amount of previous conviction in the matter from the average time of three to five minutes devoted to that end in the induction examination. Perhaps the most significant discovery on the part of all concerned relates to the realization of how tremendous a range of symptoms and maladaptations lies between the thoroughly efficient, well adjusted soldier and the frank psychotic. From this realization, which amounted to a discovery in its importance if not exactly its novelty, came the creation of a Division of Neuropsychiatry in the Surgeon General's Office comparable to those of Medicine and Surgery. Psychiatry changed from a specialty to a generality—so to speak—and the psychiatric or psychological component of illnesses previously considered as exclusively medical or surgical began to be recognized as never before. Such discoveries also brought into sharp focus the inadequacies of the usual medical history-taking and the painful incompetence and even the contempt that a large number of our medical officers commonly showed for psychiatry. No experience could have revealed more effectively than the war the nonsense of isolating psychiatry from the rest of medicine.

## Corrected Opinions

Since I doubt whether any of the above discoveries fully deserve that designation I can pass with a purist's relief to the consideration of the next

* W. C. Menninger, Bulletin of the U. S. Army Medical Dept., Vol. VII, No. 4, page 359.

category—opinions which were corrected. First, a good many psychiatrists rightly lost the complacency they had enjoyed in civilian life. The war showed conclusively that no very good way to forecast a man's threshold of endurance or his capacity to profit from help is yet known to psychiatrists. They came to see that the maintenance of morale and discipline demands that the group has to be defended against the defection and selfishness of the individual. This was an extremely significant reversal of the usual solicitudes. They came to see, too, that eliminating the most poorly endowed ten per cent of an army is not a process that can be repeated until the remainder are perfect soldiers. Psychiatrists began to realize that combat service with troops gave them understanding and status as did nothing else. They saw the power of incentive, of motivation, of loyalty, of morale as few civilian experiences ever reveal it. And the war experience also corrected any assumption that medical officers were the least likely of all army officers to be retired because of psychiatric difficulties. Indeed the assumption that officer selection in any branch of the service may best be left entirely to brother officers came in for gradual correction, and the value of a combined judgment of psychologist, psychiatrist, and line officer may be said at least to have emerged, though perhaps not to a degree of wide acceptance. Though there were some memorable exceptions, it has been heartening to observe that as a general rule the higher the echelon the greater the likelihood of support for psychiatrists of competence and character. And from the dearth of psychiatrists I hope we have learned the extraordinary value of ancillary personnel—psychologists; social workers; educational, occupational, recreational therapists; nurses and attendants.

Views not widely held at the outset of the war were gradually confirmed. Group psychotherapy and psychotherapy under sedation received skillful refinement and expansion. The costliness and futility of skimping the psychiatric examination of inductees, which was long over-ridden under the pressure of rapid expansion, became eventually evident to others than indignant psychologists and psychiatrists. The cost of these brash blunders, were it ever to be reckoned among the Veterans Administration expenses over the next fifty years, would remind me of our first surgical clinic in the medical school in 1914 when Harvey Cushing showed us an elderly man with a pain in his leg. We students all had our guesses as to the cause. It was due to a piece of lead, imbedded at the battle of Antietam.

The examination of inductees was conducted at first without any effective attempt to make use of civilian institutions whose records of the social history of a recruit would have provided prompt and valuable evidence of his adaptability and presumable stability. Only gradually was the

value of such evidence confirmed by experience. The value of having a team of psychiatrist, psychologist and social worker was established—let us hope once and for all. The importance of a thorough knowledge of anxiety, and the unvarying need of psychiatric training of all medical officers were proven as the war went on. But perhaps the most desperately and thoroughly proven view of all was that our medical schools had been giving grossly inadequate training in psychiatry. Their graduates as a rule misunderstood, ignored, and undervalued psychiatry. The number of trained psychiatrists was far below the need—so far below as to excuse almost any charge that could be levelled at the performance of the few who shouldered a staggering task. But what excuse can be offered if our medical curricula still drive onward, repeating the same mistake today—and tomorrow?

## Reflections

The experience of the war suggests a few assumptions that may deserve reflection. First, it is not too early to set a salutary example by accepting for our own profession the task of searching for significant psychological tests or psychiatric evaluation of prospective medical students. Must we leave to business, or education, or the army to find out how to foretell the threshold of endurance of external stress? Second, let us not forget that unless psychiatrists in civilian life deliberately and persistently try to bring into the psychiatric boards and specialist societies a considerable number of regular military doctors, and unless the Army and Navy continue arrangements to encourage specialization which will qualify a considerable number of their medical officers as specialists, we shall perpetuate the same handicaps of misunderstanding and friction that accompanied the efforts of the war years. Third, the promptness, the ease, the frequency, and the value of psychiatric consultations on medical and surgical wards in military hospitals suggest that psychiatric consultations in our civilian hospitals could bring equal advantage to patients and to the doctors responsible for bringing every helpful resource to bear upon the patient's problem. Fourth, there should be a major revision of medical education, for only a radical change will provide in the education of the doctor the opportunity for adequate training in the psychiatric care of human beings for a full and happy life as well as a symptom-free existence. Fifth, what are the causes for the percentage of men between 18 and 35 being disqualified for some kind of disorder of personality—14% of all the men examined? Does a social structure in peace time which shows one in seven so definitely deviant not deserve profound reflection and study? Sixth, from the war experience psychiatrists learned many of the

factors of successful leadership: the value of the leader's example, his awareness of the emotional needs of his men, his constant and manifest solicitude, his knowledge of individual men under him and his personal interest in them. Are industrial relations and problems of civilian leadership likely to be solved in complete disregard of these factors of leadership proven in the war?

Lastly, let me offer a personal opinion not only subject to immediate correction but soliciting correction if I am wrong. I do not recall during the last forty years the names of any research men in the natural sciences who ever did any notable investigative work while on the teaching staff of West Point or Annapolis. I submit that the result of an education received in institutions where students are not directly exposed to the atmosphere of research is quite naturally a mind which divides information or ideas of all kinds into only two groups: the first group comprises all ideas which are true, sound, and dependable; the other group are the ideas which are false, misleading, unproven, and unreliable. This is a deceptively precise but a dangerously inadequate attitude, for it misses the priceless imprint which comes from training in research, namely the realization that there is a still third category of ideas—hypotheses not yet known to be valid that might be true if by research they could be proven. There is an immense gap between minds trained by recitation, indoctrination, and flawless discipline in the traditional military education and minds exposed to the task of finding out what is not yet known. If cadets at West Point and Annapolis were exposed to first-rate research work, their approach throughout their subsequent careers toward finding solutions to new problems and their attitude to those who could help them in this task would be immeasurably improved. What, for example, will be the gain to military psychiatry of having psychological research of the best quality in the training of graduates from West Point and Annapolis?

## Conclusion

One final observation: the lessons of the war are clear enough. They are so nearly trite that it will take special effort if they are not to be neglected, ignored, and forgotten. Many of the lessons are humiliating—a powerful reason for repressing them. Many call for unremitting work if the mistakes are not to be continued and repeated. Circumstances make a schizoid reaction all too easy for us—a flight from reality and the escape from responsibility. The greatest unpleasant surprise of the war for medical men was the importance of psychiatry and psychology. And yet so inconstant, evasive, or preoccupied are the majority of men that this greatest lesson can be disputed, evaded, and soon forgotten.

# DEATH FROM PSYCHIC CAUSES*

By ERICH MENNINGER VON LERCHENTHAL, M.D.

## NOTE

About twenty years ago Dr. C. F. Menninger discovered a very interesting coincidence. It concerned a distant relative, distant by seven generations in fact, whose name was also Dr. Menninger! Long ago one of the Menningers from the original home near Frankfurt-am-Main had gone to Austria and had rendered such valiant service to Maria Theresa that she had knighted him and the family was given the title of von Lerchenthal. The Menninger-von-Lerchenthals continued to live in Vienna, and about 1890 established a psychiatric sanitarium in Tulln, a suburb. The founder of this sanitarium was Dr. Albert Menninger who died in 1941 at the age of 71. He had two sons, Dr. Albert Theodor and Dr. Erich Menninger. Dr. William Menninger of Topeka visited them in 1933.

In 1936 Dr. Erich Menninger published a paper dealing with a topic which has had only occasional consideration from American writers—but particularly from A. A. Brill of New York, Bernhard Berliner of San Francisco, and Nolan D. C. Lewis of New York. Dr. Brill has collected numerous instances from his own experience and that of others, including observations among primitive people, which suggest the possibility that some people can consciously will their own death and effect it without external devices; and indicate certainly that some people accurately predict their own death. Dr. Lewis reported having performed several post-mortem examinations after such death predictions had been made and fulfilled and in which he was unable to find any serious somatic pathology. The subject is still a very moot one, of course, but one of great importance in relation to theories of the self-destructive or death instinct.

Dr. Erich Menninger's contribution was sent to us and set up in galley proof eleven years ago. Rapid development of the European crisis led the editors to believe that it might cause our colleague embarrassment and even worse for his article to be published in our American journal and his relationship to us acknowledged. As it turned out, Dr. Erich Menninger is the only one of the three Vienna Menningers who survived the war, his brother having died chiefly as a result of hardships from the Nazis and his father of physical illness. The sanitarium which they had conducted for over sixty years was taken over by the Nazis and Dr. Erich Menninger is now in private practice in Vienna. He was the personal physician of Dr. Wagner von Jauregg in his last illness (pneumonia). Dr. Menninger is associated in the Vienna Psychiatric Clinic with Dr. Otto Kauders.

It is with great pleasure and pride that, with the permission of the editors of the Vienna journal in which it was first published, we now print this translation, by Dr. C. F. Menninger and Dr. Anna Moellenhoff, of our colleague's paper.

THE EDITORS.

For several years psychotherapy has been taken into account by the representatives of all the various branches of medicine and the importance of psychic influences upon organic diseases has been pointed out. On account of this, it is quite appropriate to undertake a short consideration

*Translated from *Der österreichische Arzt*, Nr. 6 (June) 1936.

of whether and within what limits the psyche of man can be a determining factor in death. The matter could be treated with varying completeness and viewed from various standpoints. We are going to start the discussion with a case cited by A. A. Friedlander, which can at the same time be a kind of *leitmotiv* of our thesis.

"Theresa Neumann predicted her death for the year 1935. We hope that she is wrong about this. However, that her life may end in the time specified by her is altogether possible, not because she has exhausted her last physical powers but because she has confronted herself with the thoughts of dying; that with the ceasing of the will to live the ability to live may also cease."

His hope was fulfilled. The stigmatized girl of Konnersreuth did not die at her self-appointed time. Everyone will acknowledge that it would have made a great and perhaps lasting impression if that death had occurred as predicted; of the opposite, however, no notice has been taken. As has been done frequently we may point to this as an example of a great source of error which must be taken into account in treating all questions on the physico-psychic border line. Also in the investigation of psychically conditioned death we must keep in mind the elective inclination of human memory to mysticism.

In the postmortem of the artist Lorenz Clasen (painter of historical subjects, born in 1812) a note was found written in his own hand which stated "I will die in my eighty-sixth year from heart failure." Such reports as bases for an unprejudiced investigation are valueless. They are too meager and offer for the most part no possibilities for reexamination. Yet they always arouse the idea that in a person whose demise is already stipulated by pathological conditions, psychic imaginings could cause death to occur at a practically definite time. The following example may illustrate this point: Joseph Haydn is said to have written in his diary on the 25th of April, 1792, "On the 26th of March at the concert of Mr. Bartholemon (London) there was an English clergyman who while hearing my Andante sank into the deepest melancholy because of the fact that on the previous night he had dreamed of such an Andante which announced his death. He immediately left the company, went to bed and today I heard through Mr. Bartholemon that this clergyman had died." This dream unquestionably was a presentiment of death owing to disturbance of the cardiac rhythm.

Proof of this may readily be procured from the literature of cardiac pathology. We may say for the moment that in such cases it is a fact, insofar as one can accept these reports as facts, that people determine to die and then do die at approximately the appointed time. Here we have the main question whether such a psychic attitude alone or in connection

with other circumstances can bring about death. In answering this we wish to differentiate between death by hysteria and death through suggestion. It is worthwhile in trying to explain cases of death for which a pathological physical condition seems less responsible than a psychic mechanism, to examine similar happenings in psychotics. It is well known that there are sudden deaths in psychoses in which pathological anatomic examination discloses no adequate cause to which death can be definitely attributed. They may perhaps represent constitutional anomalies of more or less sharply defined status thymico-lymphaticus or there may be some endocrine dysfunction or physiologically abnormal conditions of menstruation or of digestion. Sudden death in such cases is therefore explicable by the acceptance of a nervous influence upon the respiratory or circulatory system, via the parasympathetic system and through the vagus. On account of the inadequacy of explaining the cause one must posit a hypersensitivity in the vagus cerebral centers (Stefan).

It is within the realm of possibility that also in hysteric psychoses such sudden deaths occur. Aside from that, however, hysteria may end in death. With reference to such cases O. Bloch says that the desire for death is so persistent that the goal is reached through nervous exhaustion. M. Rosenfeld has remarked that the hysterical person as a rule, even when the wish for illness is strong, does not usually go so far as to wish for death itself. But one could easily imagine that the influence of the psychic emotional processes upon the somatic organs, mostly upon the vasomotor system, may proceed further than the patient himself desires; once begun the pathological process perhaps cannot be arrested or regressed and thus finally what was originally an hysterical mechanism may lead to dangerous consequences. The psychic emotional processes influence the vegetative system and it appears without doubt that they do not stop on arriving at vital centers and may thus be the cause of death. The outcome depends upon the constitution and vitality of this system and the effectivity of its cerebral centers (Rosenfeld). Klinkenberg arrives after careful consideration at the assumption that changes in the vegetative processes of the body may be brought about both voluntarily and through emotional occurrences and that it is conceivable that these together with a life-negating attitude in vegetatively unstable individuals may even lead to death.

In hysterical persons lability of the vegetative nervous system is very evident. The possibility must be acknowledged that a hysterical person may die through his hysterical imagination. A. Kronfeld relates the history of a neurotic woman of thirty-seven who for many years ate little and after each meal immediately took laxative pills, at last as many as thirty daily. She also took epsom salts in the morning and senna tea in

the evening. She consulted many physicians but would not follow their advice; she became more and more emaciated and finally died of exhaustion. Had she intended to starve to death she would be classed with cases of indirect or chronic suicide. But it appeared that she really had a neurotic fear of taking food with the possibility of death being considered but not as a conscious aim.

One remembers this case when one reads of death resulting from reducing cures. Persons who, out of excessive vanity or from vocational demands, slave for a slim figure and succeed by means of energetic dieting are suddenly confronted with life threatening situations. In spite of medical help, the return to normal diet is no longer possible. It is conceivable that the original psychic attitude may obstruct the way. Even in Theresa Neumann's case the operation of hysterical mechanisms might be possible. In her case there were many hysterical antecedents aside from the ecstacies and stigmatization. In addition, because of a fright occasioned by a fire, the menstrual period failed for a year, then reappeared irregularly several times and in 1920 in her twenty-second year it ceased completely. In an accident Theresa Neumann suffered a lumbar spinal injury, followed by paralysis and excessive complaints and has received a hundred per cent accident insurance since 1918/19. On the day of beatification of the holy St. Theresa she was cured of her hysterical blindness and on the day of her canonization she was cured of her hysterical abasia. That this hysterical woman with a peculiarly vegetative nervous, sensitive constitution (Ewald) did not die in spite of the fact that she was apparently determined that she would, is more remarkable than if the opposite had been the case. Perhaps her training in refraining from food was her salvation. The almost complete abstinence from nourishment and liquids for weeks, months and years is scientifically unacceptable (Hoche). On the other hand, it can be truly accepted that the taking of nourishment was very irregular and that the organism finally in time attained the ability to overcome the state of hunger. The period predicted also was so long that it is possible there might have been a change of mind.

We have concerned ourselves so conscientiously with this prediction of death which did not occur because science in so difficult a question as the psychic causation of death must remain by the facts, both positive and negative.

The road from the psychic to the vital organs is the nervous system; physiology supplies adequate information concerning this. If death of a person occurs with vital organs in a normal condition, then it is caused by the influence of the psyche on the nervous system. That is the only possible explanation of death through hysteria. This is confirmed by death through suggestion. It is peculiar to the hysterical mechanism

that transforms psychic contents into physical manifestations, the person being unconscious of this. When the idea of dying actually leads to bodily death the hysteric or psychogenic mechanism becomes visible in a simple form.

*Belgrad, Oct. 5, 1928—In the village Koprivnica, a farmer named Ujseck said several months ago that he would die October 4th, 1928. On the appointed day he called his family, ordered his coffin, bade farewell to his friends and at noon, as he was seating himself at the table, he died of apoplexy. The populace believing that it was a miracle was much excited.* (*Neues Wiener Tagblatt, October 6, 1928.*)

Reports of such a nature occur yearly in the various newspapers. I have before me five such notices for the years 1928, 1930, 1934 and 1935. Only men, never women, are mentioned as having foretold the time of their death to the day and the hour. Usually the directions which are to be carried out after their demise are given. It should be mentioned that the reports of one and the same case vary somewhat from one another as to time, locality, and name of person. We are not concerned with the verification of such notices* but with answering the question whether the facts considered could be possible. That is, whether a person can die according to his own prediction at a fairly definite time without showing mortal illness which would make death probable in the near future. This question can be answered affirmatively in the light of the knowledge we possess today. In connection with this the following illustration from T. H. L. Brumton (cited by L. Braun) is usually given:

An assistant was hated by the students of a college. They condemned him in a joking manner to death, carrying out the ceremony in a serious manner. The assistant was held with his head on the chopping block, eyes bandaged, while one student made the noise of a swinging axe, another dropped a warm, wet cloth on his neck. The assistant died instantly.

An analogy is furnished by an experiment cited in E. Liek's book, *Die Welt des Arztes*, page 81, which was carried out by physicians at Montpelier with a criminal. It proves beyond a doubt the possibility of death by suggestion. Coenen holds that death of a completely healthy body by means of an emotional shock is unproven and he is of the opinion that the thought of death was implanted in consciousness by a severe psychic excitement. Klinkenberg points out, on the other hand, (with citations from literature) that there are persons who can voluntarily slow down or

*It is to be regretted that physicians never report such cases. A collection of positive and negative cases would probably not alter the facts, but would help to indicate the significance of the connection between suggestion and death. See E. Menninger-Lerchenthal, Mors and Psyche. *Psychiatr-Neurology Wschr.*, 1931, No. 32.

increase the cardiac rhythm and cites Klaatsch who observed concerning Australian Negroes that the belief of being mortally endangered by a secret power can really bring about death. Though opinions concerning death in healthy persons by means of emotional shock or suggestion are not completely in agreement, it is apparent that the psyche has a powerful influence on the heart as well as on other organs through the nervous system. This influence can be decisive for life or death, especially if cardiac activity is not wholly normal. Externally the person may appear in good health but, because he is not so, he talks of death. The prophesy is a result of the subjectively felt organic disturbance and at the same time the cause of the heart stopping at a more or less definite time. The cessation of the heart beat may come with very little more load. The fear of death or the idea of having to die produces this additional load. This is the explanation offered for those cases known to doctors as well as to laymen who have died from worry, fright or other emotional shocks, as well as for those who have predicted their death at a more or less definite time. On the other hand we can accept with certainty that the power of the psyche which coöperates and functions in life's most important operations also assists in life's maintenance; for we often see all of life's willpower fighting against death. When the physician, while he is working at the bedside of a thinking man with the hypodermic of camphor, makes use of the will to live, he does not only do it because every medical action has to do with the transference of confidence from physician to patient but also because it is scientifically proved that the psychic attitude has within certain limits a power over life and death. Doctors see daily in their practice that some people show their fear of death. Others do not but one still observes it in them. Here a counter suggestion fitted to the personality of the patient is appropriate. Auto- and hetero-suggestion possess perhaps greater significance for prolongation of human life than all the so-called rejuvenescence cures. Although death which psychic efforts have helped to bring about is often clear, one sees the psychic influence on the prolongation of life only if one looks for it.

## BIBLIOGRAPHY

FRIEDLANDER, A. A.: *Muench. Med. Wschr.*, 1933, p. 226.
STEFAN, H.: *Deutsch. Med. Wschr.*, 1934, p. 1150.
ROSENFELD, M.: *Deutsch. Med. Wschr.*, 1925, p. 1060.
KLINKENBERG, F.: *Deutsch. Zschr. Gerichtl. Med.*, Bd. 1319, 1929.
KRONFELD, A.: *Psychotherap. Prax.*, Bd. 11934.
EWALD, G.: *Muench. Med. Wschr.*, 1927, p. 1981.
HOCHE, A. E.: *Die Wunder der Theresa Neumann*, Munich, F. J. Lehmann, 1933.
BRAUN, L.: *Psychogenesie u. Psychotherapie Korperliche Symptome.* .Heransg. O. Schwarz.-Verlag, J. Springer, Wien, 1925.
COENEN, H.: *Muench. Med. Wschr.*, 1926, p. 1 and p. 66.

## BOOK NOTICES

*Psychiatric Interviews with Children.* By HELEN LELAND WITMER. Price $4.50. Pp. 443. New York, Commonwealth Fund, 1946.

This book is a valuable contribution to the literature on child guidance psychiatry. It is mainly composed of ten case records selected from various American child guidance clinics. The records reproduce in detail what went on between the therapist and the patient and illustrate some of the techniques used in child guidance. A series of footnotes provide a running commentary on and interpretation of the words and actions of both the child and the therapist. All the therapists are either analysts or are analytically oriented and have had years of training and experience in psychotherapeutic work with children. This book should be of great interest to everyone dealing with emotional problems of children. (R. Henkins).

*Sexual Inadequacy of the Male.* By PAUL POPENOE, Sc.D. Price $1.00. Pp. 41. Los Angeles, The American Institute of Family Relations, 1946.

The treatment of the subject in this "Manual for Counsellors" is superficial and loaded with cliches, such as "general re-education," "building up his self-confidence" and "forming a new set of attitudes and habits." While an area exists in which "counselling" is applicable, the unfortunate extension of this to regions beyond the scope of the relatively untrained "counsellor" occurs. While the author's motivation is not in question, the damage that may be done by such "counselling" of a severely maladjusted individual is obvious. Numerous brief case histories are used to illustrate the technique and in speaking of one of these, the author states "In other cases the man may be on the borderline of schizophrenia, but it is not necessary to be too pessimistic or alarmist about such a client, in view of the severe and erroneous conditioning that many persons have had in childhood." To describe this approach as extremely dangerous is euphemistic. (J. T. Thickstun).

*Aftermath of Peace.* By A. M. MEERLO. Price $2.50. Pp. 218. New York, International University Press, 1946.

This is an earnest psychological study of the postwar situation by a psychiatrist who himself suffered much. It would be of particular interest to people working with those who had been in occupied countries or who had suffered through imprisonment. (K. A. M.).

*Alcohol, Science and Society.* Twenty-nine Lectures with Discussions as Given at the Yale Summer School of Alcoholic Studies. Price $5.00. Pp. 473. New Haven, Quarterly Journal of Studies on Alcohol, 1945.

This book is a compilation of twenty-nine separate lectures as presented

by twenty-four lecturers at the Yale Summer School on Alcoholic Studies. Its outstanding value lies in the fact that it presents the problem from the viewpoints of the medical man, the physiologist, the psychiatrist, the psychologist, the anthropologist, the sociologist, the theologian, the economist, and the lawyer, by which approach it successfully presents the problem from a wider orientation than is possible in less comprehensive works. The lectures are presented on a level to be understandable to professional workers who have a limited knowledge of alcoholism. Individually the lectures are fairly elementary and some are dull, but collectively the lectures represent a book which is a serious and successful attempt to present a broader understanding of the origins, scope, and ramifications of alcoholism. This volume has limited value as a source book, but to those who are inclined to look at alcoholism from the narrow cloisters of their own fields, it is an invaluable orientation; and even to those who recognize the scope of alcoholism, the book serves as a good reminder that alcoholism is bigger than any one specialty or field. The book is recommended to those interested in social problems and to those who have to work with alcoholics but whose orientation in the field is limited. If it were a little less technical it could be understood by the legions of people who find themselves propounding cures for alcoholism without having any conception of the real problem. (Murray Bowen).

*Anti-Semitism: A Social Disease.* Edited by ERNST SIMMEL. Price $2.50. Pp. 140. New York, International Universities Press, 1946.

Seven earnest, socially-conscious, psychoanalytic-minded people, among whom are sociologists as well as psychiatrists, have gotten together 140 pages of discussion about anti-Semitism. Sociological, psychoanalytic and political theories are advanced in a thoughtful, well written form.

The people who read the book, however, will be those who already regard anti-Semitism as a disease of society. Those members of society whose symptoms constitute the disease will unfortunately not look at it. (K. A. M.).

*Progress in Neurology and Psychiatry.* Edited by E. A. SPIEGEL. Price $8.00. Pp. 708. New York, Grune & Stratton, 1946.

This seven hundred page book is designed as a review of the current contributions during the year 1945 to neurology and psychiatry. In many ways it seems very similar to the Year Book in neurology and psychiatry, although the preface states that it is "not intended to replace existing abstract services." Edited by the Professor and Head of the Department of Experimental Neurology at Temple University School of Medicine, thirty of the 39 chapters are devoted to neurology and neuroanatomy, each by different authors. The nine chapters devoted to psychiatry, composing only 160 pages in the book, are contributed by well known psychiatrists. Each chapter is a summary of recently published work and in some instances there is a critical evaluation of it and some not. It is more readable than the Year Book because various related subjects are woven together in a continuum. (W. C. M.).

*Trends of Mental Disease.* By The American Psychopathological Association. Price $2.00. Pp. 114. Morningside Heights, New York, King's Crown Press, 1945.

*Trends of Mental Disease* is essentially a series of statistical statements of the rates and kinds of mental disease, presented at a symposium of the American Psychopathological Association. Various statistical approaches have produced no definitive statements concerning the waxing or waning of mental disorders. From the present to the future, interpolated curves give different results based on various assumptions concerning fertility and mortality rates. Perhaps most valuable in the volume is an inspection of the nosological groupings, and Commander Francis Braceland's presentation of the problem as it appeared in the Navy. (R. E. W.).

*Studies of Compulsive Drinkers.* By Herman Wortin, M.D.: Leonard R. Sillman, M.D. and Florence Halpern, M.A. Price $1.00. Pp. 90. New Haven, Connecticut, Hillhouse Press, 1946.

Part I of this little volume presents the case histories of 18 alcoholics together with a brief psychological test report on each case. Its aim is to present the student with reliable material in place of the usual fictional and autobiographical accounts of alcoholism. In the foreword Dr. Nolan D. C. Lewis emphasizes that comparison of a large number of such case histories with the histories of non-alcoholics revealed no single event or relationship which could significantly distinguish the two groups, and that the differences accordingly must lie in the totality of environmental stress and individual predisposition. No synthesis of all the case histories is offered.

Part II presents an analysis of the results of a battery of tests administered to 47 alcoholics. The battery consists of the Wechsler-Bellevue Scale, the Rorschach Test, a simple level of aspiration test and an unpublished Vocational Interest Inventory by D. Wechsler, designed to indicate masculinity and femininity of interests. Some suggestive findings are presented. (Roy Schafer)

*Psychiatry Today and Tomorrow.* By S. Z. Orgell, M.D. Price $6.00. Pp. 560. New York, International Universities Press, 1946.

Although Doctor Orgell implies that this is a book concerned with dynamic psychiatry, his over-emphasis on the psychoses, and the de-emphasis on the neuroses and character disturbances indicate that the author is more interested in the classical type of psychiatric thinking. He very hurriedly covers the psychological development of the individual and mental mechanisms, and devotes only a few pages to psychoanalysis as a form of therapy. This discussion of the mental mechanisms leaves much to be desired, as he gives many definitions but fails to give illustrations from daily life or clinical practice which might make these definitions more real.

The author gives good clinical descriptions of the psychoses and illustrates these with good case material. However, he adds little not already available in text books of descriptive psychiatry, and does not, in the reviewer's opinion, help matters much by including such brief state-

ments regarding the dynamic aspects of the conditions which he discusses. (L. L. Robbins)

*The Varieties of Temperament.* By W. H. Sheldon and S. S. Stevens. Price $4.50. Pp. 520. New York, Harper & Brothers, 1942.

The book is an attempt to show a systematic concomitancy between morphological characteristics of individuals and a scale of psychological traits. The physiques and temperaments of 200 young men were studied to furnish the basic data. The "somatotypes" are expressed in a three numeral series showing the approximate strength, on a 7 point scale, of three primary components of physique. The relationship between the somatotypes and the chosen psychological traits (60 in all) becomes the basis for an analysis of personality structure. Components of temperament are expressed in terms having physiological significance, thus giving emphasis to "constitutional factors" in personality differences. The book devotes considerable space to descriptions of morphological and temperamental variables, and in closing gives extensive correlational data in support of the main contentions of the authors. (Albert C. Voth)

*Technique of Psychoanalytic Therapy.* By Sandor Lorand. Price $3.50. Pp. 251. New York, The International Press, 1946.

This book is primarily for students of psychoanalysis in the last year or so of their training. Doctor Lorand is a strong advocate of elastically applied "active technique" and succeeds in showing that the analytical situation does not depend on formal rules, such as for example the reclining position of the patient, or the avoidance of giving suggestions in certain cases. When the analyst knows what he is doing and why, he has a considerable latitude in molding his attitude to the patient's needs. The author exemplifies convincingly that there are no dogmatic prescriptions on how to manage the patient's transference or when to give interpretations. He stresses, of course, the paramount importance of the analysis of the transference, which indeed remains the criterion of where psychoanalysis ends and psychotherapy begins.

There are times when the adherence to the fundamental rule is inadvisable, as in a case of Doctor Lorand's quoted in this book. The chapters on counter-transference, phenomena and termination contain lucid views and give invaluable advice derived from long experience and mature views. (Jan Frank)

*Are You Considering Psychoanalysis?* By Karen Horney, M.D. Price $3.00. Pp. 262. New York, W. W. Norton, 1946.

Nine familiar and sensible questions are asked in the chapter titles of this book such as: "What are your doubts about analysis?", "Who should your analyst be?", What does the analyst do?", "How does analysis help?"

All of the authors who answer these questions belong to a circle of colleagues and students of Dr. Karen Horney. Their answers while uneven in clarity and styllistic grace, correspond in the main to prevalent conceptions, despite repeatedly interpolated flourishes to the effect that in some obscure way the Horney version is a vast improvement over the benighted techniques of the "orthodox" practitioners of psychoanalysis. (K. A. M.)